IN CASE OF MEDICAL EMERGENCY

I understand that every effort will be made to contact the parents/guardians (if under age), or my emergency contact. However, permission is hereby granted to:

____

(person authorized by Little River Baptist Association to make this decision, usually the mission director)

to authorize treatment by a physician to perform necessary medical treatment, including injection, anesthesia, or surgery for my child (if under age) or myself until such time as parents/guardians, or my emergency contact can be reached.

Signature (Parent or Guardian if applicant under age 18)

____Date_______________

Hospitalization Insurance:

Company____

Policy or Identification Number____

Name of Insured____

List of all known allergies:

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Persons to be contacted in case of emergency:

Parents:____Home Phone:_______________

Work or Cell Phone:_______________

Spouse:____Home Phone:_______________

Work or Cell Phone:_______________

Other:____Home Phone:_______________

Work or Cell Phone:______________